**WJL Administrative Services, LLC**
**dba WJL Benefits Plan**
**54 Westchester Drive, Suite 20**
**Austintown, Ohio 44515**
**Phone: 330-953-2307**
**Fax: 330-953-2310**

# Enrollment Form

***Reason for Enrollment***
**New Enrollment** _____
**Change** _____
**Termination** _____

| EMPLOYEE GROUP NAME | LOCATION | CLASSIFICATION |
|---|---|---|
| | | |

| EMPLOYEE NAME | SSN# | Date of Birth | Sex M/F | Hire Date | Effective Date |
|---|---|---|---|---|---|
| | | | | | |

Address_____ City:_____ State:_____ Zip:_____

Employee Home Phone:_____ Employee Work Phone:_____

Employee Email Address:_____ Other Insurance Coverage: _____
*Carrier Name*

Dependents - ***Attach a separate sheet if needed***

| Name | SSN# | Dependent Status | Date of Birth | Sex M/F | Full-time Student Y/N |
|---|---|---|---|---|---|
| | | Spouse _____ | | | |
| | | Child _____ Other _____ | | | |
| | | Child _____ Other _____ | | | |
| | | Child _____ Other _____ | | | |
| | | Child _____ Other _____ | | | |

***Coverage: Check all that apply***

| Medical | Dental | Vision | RX | HRA | FSA | Life | Coverage Waived |
|---|---|---|---|---|---|---|---|
| | | | | | | | Yes ____ No ____ |

***Coverage Waived:***
***Check all that apply*** ***Reason for Waiver***

| | |
|---|---|
| Medical _____ | Covered by Spouses Group Plan _____ Medicare Eligible _____ Individual Coverage _____ Other _____ |
| Dental _____ | Covered by Spouses Group Plan _____ Medicare Eligible _____ Individual Coverage _____ Other _____ |
| Vision _____ | Covered by Spouses Group Plan _____ Medicare Eligible _____ Individual Coverage _____ Other _____ |
| RX _____ | Covered by Spouses Group Plan _____ Medicare Eligible _____ Individual Coverage _____ Other _____ |
| Life _____ | Covered by Spouses Group Plan _____ Medicare Eligible _____ Individual Coverage _____ Other _____ |

***I acknowledge that I have read and completed this enrollment form and I represent that all answers are true and accurate to the best of my knowledge. I understand that the answers given will be relied upon by the insurance administration. I understand that misstatements or failures to present information may result in coverage(s) and benefits being denied, rescinded or cancelled.***

_____ _____
Signature Date